

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-037149

STATE FILE NUMBER

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 121

FILED SEP 24 1963

DO NOT WRITE  
ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

USE BLACK INK

OR

TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>Pike</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Pike</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Louisiana</b>		Length of stay in 1b <b>Life</b>	c. CITY OR TOWN <b>Louisiana</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Residence</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>409 Main Street</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Dawson Perry Grady</b>		4. DATE OF DEATH Month Day Year <b>Sept. 17, 1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-12-77</b> 9. AGE (last birthday) <b>86</b> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nursery man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fruit Nursery</b>	
11. BIRTHPLACE (City and state or country) <b>Pike Co., Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>James Grady</b>		13b. MOTHER'S MAIDEN NAME <b>Artie Missa Perry</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>[REDACTED]</b>	
17. INFORMANT <b>Mrs. Mary L. Briles, Louisiana, Mo.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO (b) <b>Generalized Arteriosclerosis</b> with <b>Pyelonephritis, blindness and severe</b> secondary <b>anemia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>12/5/42 Fracture of hip, right</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b> <b>5+ yrs.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>1959</b> to <b>9/17/63</b> and last saw him alive on <b>9/17/63</b> Death occurred at <b>9/17/63</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Chris H. Llewellyn M.D.</b>		22b. ADDRESS <b>122 S. 3rd St. Louisiana, Mo.</b>	
22c. DATE SIGNED <b>9/19/63</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9-19-63</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Louisiana, Mo.</b>	
24. FUNERAL DIRECTOR <b>Geo. M. Collier, Louisiana, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>9-19-63</b>	
26. REGISTRAR'S SIGNATURE <b>Bernice Collier</b>			

(Licensed Embalmer's Statement on Reverse Side)

015-100-500

DATE

TIME

DECEASED

DECEASED

DECEASED

DATE OF DEATH

DECEASED

DATE OF DEATH

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Geo. M. Collier

Licensed Embalmer No. 3839

P. O. Address Louisiana, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.